American Society of Anesthesiologists®
Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

September 2016

Does the Future Include Unwrapping the Global Surgical Package?

The Centers for Medicare and Medicaid Services (CMS) proposed rule for the CY 2017 Physician Fee Schedule (PFS) continues the discussion of analyzing and updating potentially "misvalued" codes. This discussion has been going on since 2009. One of the more significant areas under review is procedure codes which include a 10-day or 90-day global period. This Timely Topic describes CMS's proposed action in regard to such services and how this may effect ASA members – notably those who practice pain medicine.

CMS assigns a global period to most procedures. You can find out what global period is assigned to a specific CPT® code via the Physician Fee Schedule Search tool.

Global period assignments include:

Global	Description	Example
000	Includes the work on the day of the procedure	64483 – Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
010	Includes pre-operative and operative services included on the day of the procedure plus any related services provided up to 10 days following the procedure	64633 – Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
090	Includes pre-operative services on the day before the procedure, the services on the day of the procedure and any related services provided up to 90 days following the procedure	63664 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
XXX	Global concept does not apply	95991 - Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional
ZZZ	Code is related to another procedure and is included within the global period assigned to that primary procedure	64484 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

In the CY 2015 Physician Fee Schedule (PFS) Final Rule, CMS announced that all 10-day global periods would be converted to zero day globals by 2017 and that all 90-day global periods would be changed to zero global periods by 2018. Section 523(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibits that policy from going into effect until additional information is gathered. MACRA requires that additional data collection effort start by January 1, 2017.

The CY 2017 PFS proposed rule describes a three-pronged approach to this data collection:

- Claims-based reporting by all providers using new (no pay) G-codes to represent the number and level of both pre- and post-operative visits furnished during the 10- and 90-day global periods;
- A survey of a representative sample of providers about the activities and resources used in providing pre- and post-operative services during the global period; and
- A more in-depth study, including direct observation of the pre- and post-operative services delivered in a small number of sites, including some ACO's.

CMS is proposing to establish the following new G-codes for the claims-based reporting approach:

TABLE 9—PROPOSED GLOBAL SERVICE CODES

Inpatient	GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package.
	GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package.
	GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package.
Office or Other Outpatient	GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package.
	GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package.
	GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package.
Via Phone or Internet	GXXX7	Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package.
	GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package.

Source: CMS-1654-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

If finalized as proposed, all physicians and other healthcare professionals who provide services that are assigned a 10 or 90 day global period will need to be able to capture the level of detail encompassed in these proposed G-codes. CMS provides examples of activities that would be included in a typical visit in the proposed rule:

TABLE 10—ACTIVITIES INCLUDED IN TYPICAL VISIT (GXXX1 & GXXX5)

Review vitals, laboratory or pathology results, imaging, progress notes
Take interim patient history and evaluate post-operative progress
Assess bowel function
Conduct patient examination with a specific focus on incisions and wounds, post-surgical pain, complications, fluid and diet intake
Manage medications (for example, wean pain medications)
Remove stitches, sutures, and staples
Change dressings
Counsel patient and family in person or via phone
Write progress notes, post-operative orders, prescriptions, and discharge summary
Contact/coordinate care with referring physician or other clinical staff
Complete forms or other paperwork

Source: CMS-1654-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

ASA and other societies have expressed concerns about the first "prong". In our comments to CMS, ASA wrote, *"The claims based data collection process as proposed will be complex, burdensome and a distraction from patient care. If CMS finalizes its proposal, physicians will have to develop and implement new and complex processes to comply. This will result in increased costs and diversion of resources away from important patient-focused activities."*

The data collection will occur throughout calendar years 2017 and 2018. MACRA requires CMS to apply the findings from these data collection efforts to the CY 2019 Physician Fee Schedule.

The CY 2017 PFS Final Rule will include CMS's responses to the comments and concerns it received. That rule is typically published by early November and its policies go into effect on January 1, 2017. ASA will issue alerts and provide information to all members detailing the specific requirements once they are known.